U.S. Department of Labor

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Issue Date: 03 May 2006

Case No.: 2003-BLA-5232

In The Matter of:

JOHN R. McGREEVY
Claimant

v.

CONSOLIDATION COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-In-Interest

DECISION AND ORDER ON REMAND – AWARDING BENEFITS

This matter is before me on remand from the Benefits Review Board (the "Board"). In its Decision and Order dated March 29, 2005, the Board vacated in part my Decision and Order Awarding Benefits issued on December 11, 2003 and remanded the case for further proceedings consistent with its opinion. In particular, the Board affirmed the finding that the existence of pneumoconiosis had been established pursuant to 20 C.F.R. § 718.202(a)(1) but vacated the finding that the existence of pneumoconiosis had been established pursuant to 20 C.F.R. § 718.202(a)(4). The Board affirmed the findings I made that the opinion of Dr. Basheda was too equivocal to support a finding of the existence of pneumoconiosis and that the opinion of Dr. McMonagle concerning the existence of pneumoconiosis was neither well-reasoned nor well-documented. The Board found that because I had found the medical opinion of Dr. Basheda too equivocal to support a finding of the existence of pneumoconiosis, it was error then to rely upon his opinion as supportive of Dr. Garson's opinion, when finding that pneumoconiosis had been established pursuant to 20 C.F.R. § 718.202(a)(4). According to the Board, this reliance was not rational.

With regard to the opinion rendered by Dr. Garson, the Board held that I failed to address whether his diagnosis of coal workers' pneumoconiosis was merely a restatement of an x-ray opinion and to explain why Dr. Garson's opinion was more persuasive than the contrary opinions of Drs. Fino and Renn. Given that Dr. Garson also diagnosed chronic bronchitis, which met the legal definition of pneumoconiosis, the Board directed that this finding needed to be addressed as to whether it was sufficiently reasoned.

The Board found it error to discredit the opinion of Dr. Fino because he could not provide an exact cause for Claimant's idiopathic fibrosis, holding that the Employer is not required to establish the etiology of the miner's lung disease. Similarly, the Board found that I discredited Dr. Renn's opinion because the doctor indicated that Claimant's idiopathic pulmonary fibrosis was probably the result of tobacco smoking, but also indicated that interstitial lung disease can have a mixed dust cause, pointing out that I had failed to address the fact that Dr. Renn also opined that none of Claimant's diagnoses were either caused or contributed to by his exposure to coal dust, Dr. Renn having explained the bases for his conclusion that Claimant did not suffer from coal workers' pneumoconiosis.

Having vacated the findings rendered pursuant to 20 C.F.R. § 718.202(a)(4), the Board also vacated the finding that the newly submitted evidence, when weighed together, was sufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a), and therefore, that Claimant had established that one of the applicable conditions of entitlement had changed since the prior denial. If, on remand, the existence of pneumoconiosis were found, the Board directed that the issue of the causation of total disability would need to be reconsidered.

On the issue of total disability, the Board affirmed the findings made pursuant to 20 C.F.R. § 718.204(b)(2)(i)-(iii), but directed further consideration of the issue of whether the medical opinion evidence was sufficient to establish total disability pursuant to 20 C.F.R. § 718.204(b)(2)(iv). The Board found error in not addressing whether the opinions of Drs. McMonagle and Garson regarding the extent of Claimant's pulmonary impairment were sufficiently reasoned and in failing to discuss whether Dr. McMonagle's relationship with the Claimant, given that he is the Claimant's former son-in-law, had any effect on the credibility of his opinion. The opinions of Drs. Fino and Renn were also to be reviewed in light of the Claimant's work and their respective assessments of his ability to perform the exertional requirements of his most recent coal mine employment. Also required was an assessment of whether Claimant's work involved moderate or heavy labor.

Prior to a discussion regarding the weight to be accorded the medical opinions, it is appropriate to review the definition of pneumoconiosis. The regulations define pneumoconiosis broadly and as follows:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal" pneumoconiosis.
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> (1) *Clinical Pneumoconiosis.* "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary

fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201.

Asthma and asthmatic bronchitis have been found to fall under the regulatory definitions if they are related to coal dust exposure. *Tokarcik v. Consolidation Coal Co.*, 6 BLR 1-666 (1983).

Medical Opinion Evidence

In my decision, I found that Dr. Basheda's opinion, that the Claimant suffered from diffuse lung disease which may represent a mixed dust pneumoconiosis, i.e., anthracosilicosis and asbestosis, to be equivocal at best, failing to affirmatively diagnose a coal mine dust related condition. For this reason, I found his opinion insufficient to meet Claimant's burden of proof. While the Board found it was not rational to find his report to be supportive of that of Dr. Garson, given that I had "discredited" his report, this is a mischaracterization of the finding made. The report of Dr. Basheda was not discredited, but found insufficient to meet a burden of proof. Thus, while his report was not sufficient in and of itself to establish the existence of pneumoconiosis, it did, in fact, lend credence to the report of Dr. Garson, inasmuch as Dr. Basheda found that the lung disease suffered by the Claimant might be related to two factors: his coal mine employment and his asbestos exposure. The Claimant was exposed to asbestos siding in some of the preparation plants and, at times, Claimant was required to work on that siding. Given that both of these exposures occurred while working in the coal mines, his opinion points to a coal mine related pneumoconiosis. This is in sharp contrast to the opinions of Drs. Renn and Fino who specifically rule out the possibility of a coal mine related pulmonary condition.

Even if the opinion of Dr. Basheda is not considered to be supportive of Dr. Garson's opinion, for the reasons set forth below, I find that the opinion of Dr. Garson is sufficient to outweigh those of Drs. Renn and Fino. As I did previously, I continue to find the opinion of

Dr. McMonagle to be worthy of little weight. Therefore, how his relationship with the Claimant weighs on his credibility is of no relevance herein.[1]

To briefly review the pertinent medical reports, Dr. Gregory Fino examined the Claimant in January of 2002. (DX 14). Dr. Fino is board-certified in internal medicine and in pulmonary disease. He recorded a cigarette smoking history of one and a half packs per day for ten years, the Claimant having started and stopped smoking some time during the 1950s. Claimant was currently smoking a cigar once or twice a week. Twenty-eight years of coal mine employment was recorded, with five years underground and twenty-three years above ground. Claimant's last position as senior maintenance engineer did not require heavy labor. According to Dr. Fino, the Claimant did not recall any asbestos exposure. Based upon his examination, which included the taking of histories, a chest x-ray, pulmonary function study, and blood gas testing, as well as a review of the medial evidence, Dr. Fino opined that the Claimant suffered from diffuse interstitial pulmonary fibrosis. He found no evidence of a coal mine dust related pulmonary condition and concluded that the pattern of abnormality found on the chest x-ray was consistent with his diagnosis. Dr. Fino stated that, had the Claimant indicated a history of asbestos exposure or cobalt exposure, then a diagnosis of asbestosis or hard metal disease would be appropriate. Dr. Fino found an abnormality evidenced in the diffusing capacity which would prevent the Claimant from performing heavy manual labor but would not prevent Claimant from returning to his last classified position of senior maintenance engineer. In his report, Dr. Fino noted that the Claimant's carboxyhemoglobin level was normal.

The deposition testimony of Dr. Fino was taken in June of 2003. Dr. Fino testified that the Claimant seemed to have a lot of permanent fibrosis. He further testified that none of the Claimant's lung disease was caused by Claimant's history of tobacco smoking. Dr. Fino reiterated that the occupational pneumoconiosis that could best explain all the findings in this miner would be asbestos, although he was not making that diagnosis. Dr. Fino found no evidence of chronic bronchitis causing obstruction in the Claimant. He did find rales, which were indicative of fibrosis in his lungs.

Dr. Fino stated that he found irregular opacities on chest x-ray, which would be consistent with a pulmonary fibrosis. Pneumoconiosis causes a rounded opacity and the worst part of the x-ray is the upper lung zones, not the lower lung zones. While from an occupational standpoint, the type of exposure which would account for these findings included asbestos, of the non-occupational causes, the most common was idiopathic diffuse pulmonary fibrosis, which is not really a pattern described in coal workers' pneumoconiosis. While Dr. Fino testified that he classified the pulmonary function testing as normal, the Claimant had a lung condition which had developed and worsened since 1986.

Dr. Fino had the opportunity to review the testing conducted by Drs. Renn and Garson, which he found to be consistent with the testing he conducted. The spirometry performed by Dr. Renn revealed worse values and the x-ray findings had also progressed. These changes were the result of the Claimant's underlying lung disease, his diffuse idiopathic interstitial pulmonary

[1] It is to be noted that in my prior decision, in the discussion regarding disability, I found that all the physicians, including Dr. McMonagle, found the Claimant to be disabled.

fibrosis. While this rapid progression was consistent with idiopathic interstitial pulmonary fibrosis, it was not consistent with a coal dust related condition. Dr. Fino stated that he could not be certain what the etiology of the Claimant's lung problem was, but he could rule out coal dust exposure because coal mine dust exposure does not cause this pattern of abnormality on the chest x-ray nor does it cause the marked drop in pulmonary function test results and it does not get worse in a period of fifteen months, as happened in this case. According to Dr. Fino, coal workers' pneumoconiosis causes fibrosis which is focal, not diffuse. He testified that legal pneumoconiosis describes a whole host of coal dust related conditions, not each of which is progressive.

Dr. Fino noted that Claimant told Dr. Renn that he had chronic bronchitis adding that he would "give him chronic bronchitis in the terms of a diagnosis, but it's like his smoking; it's causing no problem at all." According to Dr. Fino, the idiopathic interstitial pulmonary fibrosis evident here usually occurs in the older years and it was not unusual. This was definitely not coal workers' pneumoconiosis because there were primarily irregular opacities and there was no involvement in the upper lung zones.

Dr. Fino did find disabling lung disease, "based on the scenarios" given to him including employment which required that the Claimant walk briskly ten miles a day or walk up several flights of steps. Dr. Fino found that walking up a flight of steps as often as one time an hour in an eight hour day would be difficult for the Claimant. Dr. Fino opined that if Claimant were required to climb steps throughout his shift and walk at a brisk pace up to ten miles in an eight hour shift, this would involve sustained aerobic moderate labor and Dr. Fino did not think Claimant would be able to perform that kind of labor because it would be more than Claimant's pulmonary process would allow. Dr. Fino concluded the Claimant would have trouble doing that because of an impairment in getting his oxygen from the air sacs to the bloodstream. This was due to Claimant's idiopathic interstitial fibrosis which, when asked what its cause was, Dr. Fino responded, "I don't know the answer to that." Coal mine dust, however, could be ruled out with medical certainty. Dr. Fino stated that while the Claimant's chest x-rays could be consistent with pneumoconiosis, when the entire clinical information was reviewed, they were not. Dr. Fino agreed that pneumoconiosis can cause an abnormal diffusing capacity.

Dr. Garson examined the Claimant in October of 2002. (EX 3). He also had the opportunity to review medical records, including treatment records and the reports of Drs. Fino, McMonagle, and Celko. Based upon his examination and review of evidence, Dr. Garson concluded that the Claimant suffered from pneumoconiosis as well as chronic bronchitis. Dr. Garson is board-certified in preventative medicine. In his report, Dr. Garson recorded that the Claimant started smoking cigarettes approximately twenty-five years ago and quit smoking eight or nine years ago, having consumed a pack per day. Claimant also chewed tobacco for eight to ten years. Twenty-eight years of coal mine employment was recorded, fourteen aboveground and fourteen underground. Past medical history included a triple bypass, some back surgery, and illnesses primarily involving his cardiac system. Dr. Garson conducted pulmonary testing as well as an EKG and a chest x-ray. In the left lower posterior chest there were wheezes and some rhonchi heard. He found no cyanosis, clubbing, or edema. Based upon his examination, he diagnosed simple coal workers' pneumoconiosis, hearing disorder, edentulous with dentures, microscopic hematuria, ASCVD, status post triple bypass, first degree A-V block with left atrial

abnormality, chronic bronchitis, arthritis of the shoulder and back, and suspicion of gout in the toes. Dr. Garson concluded that the Claimant would not be able to sustain the level of activity required in his last position as a senior maintenance engineer, which included walking at a brisk pace up to ten miles in an eight hour shift. It was his opinion that the Claimant was disabled from his last coal mine work and that pneumoconiosis was a substantially contributing cause. Cigarette smoking and coal mine dust exposure were both factors in his disability. Dr. Garson pointed out that while Claimant had been a long time smoker, he only smoked cigars occasionally at the present time. Claimant had x-ray evidence of more than the average coal workers' pneumoconiosis, and his breathlessness seemed to be much more than one would attribute to the amount of smoking he had done in the past or continued to do.

In his deposition, taken in 2003, Dr. Garson testified that he works at the Centerville Clinics, Inc. as the medical director emeritus, having previously been the medical director. At the time of the taking of his deposition, he worked one day a week seeing patients. Previously, he had worked with the Consolidation Coal Company, first as their assistant and finally as the medical director. He explained that he had worked with Consolidation Coal Company, with the federal government, and with the union, in the occupational lung disease area. He also went to Europe in the late 1960s to review coal workers' pneumoconiosis with the British.

Dr. Garson testified that the Claimant indicated he had fourteen years of underground coal mine employment and fourteen years in construction and repair of preparation plants. The Claimant underwent a triple bypass approximately six year prior to the examination and had undergone back surgery as well. The Claimant explained to him that he could no longer perform the exertional requirements of the job, including walking at least ten miles, along with climbing, because of his shortness of breath. A cigarette smoking history of about a pack per day, starting twenty-five years ago was recorded with the Claimant having quit eight or nine years ago. Claimant smoked two cigars a day and had also chewed tobacco for seven to eight years. Dr. Garson termed Claimant's smoking history multiple and fairly definite. Dr. Garson pointed out that Dr. Fino, in his report, recorded a smoking history of a pack and a half a day and possibly more when the Claimant was stressed.

Dr. Garson stated that the Claimant had chronic bronchitis. In his opinion, the chest x-rays were positive for pneumoconiosis. Pulmonary function testing showed no obstructive lung defect at rest, although a restrictive lung defect could not be excluded. The oximetry was normal. No test was performed to determine Claimant's diffusing capacity. Based upon his examination and the history provided to him, Dr. Garson stated that he felt that the Claimant suffered from coal workers' pneumoconiosis, a simple variety. He also diagnosed chronic bronchitis, which he found to be related in part to the exposure to coal dust. Dr. Garson explained that pneumoconiosis is caused by exposures to coal dust and it could reach a diagnosis of being interstitial pneumonia. When asked whether he agreed with the diagnosis rendered by Dr. Fino, namely, that the Claimant suffered from diffuse interstitial fibrosis not related to coal mine employment, Dr. Garson stated his disagreement in light of the Claimant's exposure to coal mine dust over a period of time. According to Dr. Garson, Dr. Fino's diagnosis presupposed a lung that had not been exposed to any dust, which was not the case here. Dr. Garson reiterated what he was told was Claimant's last coal mine job. It consisted of walking at least ten miles a day and climbing up and down ladders. Claimant was no longer doing heavy construction or

repair activities. Dr. Garson opined that the Claimant was totally disabled from his last coal mine work, as a result of his coal workers' pneumoconiosis and his bronchitis. The latter was due, in part to his cigarette smoking, but Claimant's coal workers' pneumoconiosis worsened his chronic bronchitis. While he could not separate out how much the occupational dust versus the personal dust of smoking contributed, he opined that both were causative factors. Dr. Garson stated that he assumed the Claimant consumed about a pack a day of cigarettes for thirty-five years or more.

Dr. Joseph J. Renn examined the Claimant in April of 2003. (EX 4). Dr. Renn is board-certified in internal medicine, pulmonary disease, and forensic medicine. Dr. Renn recorded that the Claimant worked as a coal miner from 1949 to 1950 and again from 1960 until 1988. His last job was as a construction engineer repairing preparation plants. Claimant indicated he believed he was exposed to asbestos in the form of asbestos siding. A smoking history from 1943 to 1950 at the rate of two packages of cigarettes per day was recorded with Claimant consuming six to eight little cigars daily from 2001 to present. From 1960 until 1971, he chewed a package of tobacco daily. Dr. Renn noted that medical records indicated a smoking history of one and one-half packages of cigarettes per day since the age of seventeen years, continuing until approximately 1997. Based upon his examination, which included the taking of histories, chest x-ray, pulmonary function, and blood gas testing, as well as the review of medical records, Dr. Renn concluded that Claimant suffered from idiopathic pulmonary fibrosis, probably usual interstitial pneumonitis (UIP) owing to tobacco smoking. He also found probable pulmonary emphysema owing to tobacco smoking and chronic bronchitis owing to tobacco smoking. Dr. Renn opined that the Claimant did not suffer from pneumoconiosis. Dr. Renn concluded "with a reasonable degree of medical certainty," that the Claimant's UIP, probable pulmonary emphysema, and chronic bronchitis resulted from his years of tobacco smoking rather than exposure to coal dust. He further found that the Claimant's idiopathic pulmonary fibrosis, "which is probably usual interstitial pneumonitis," also resulted from tobacco smoking rather than exposure to coal mine dust. Dr. Renn concluded that, when considering only his respiratory system, the Claimant was not totally and permanently impaired to the extent that he would not be able to perform his last coal mining job of construction engineer or his next-to-last job of superintendent of a cleaning plant. According to Dr. Renn, the hardest part of Claimant's last job was staying on the job up to four days at a time 24 hours each day, and that according to Claimant, the heaviest part of the job was that he would help the guys carry gas and oxygen tanks even though he was not supposed to. Dr. Renn related that Claimant advised him that the hardest part of the superintendent position was dealing with the workers. Dr. Renn found the Claimant's carboxyhemoglobin level to be consistent with an individual who is intimately exposed to products of combustion such as tobacco smoke.

The deposition testimony of Dr. Renn was taken in June of 2003. (EX 11). Dr. Renn testified that the Claimant's last two jobs were fairly light jobs because the Claimant "didn't really have to do anything." According to Dr. Renn, the heaviest thing the Claimant had to do was just help the workers, even though he was not supposed to help them. While he knew the Claimant was required to walk as much as ten miles in an eight hour shift, in his opinion, the work was still fairly light. If Claimant were also required to climb ladders or stairs, then the work would be moderately heavy and the Claimant retained the pulmonary capacity to perform this type of work. Dr. Renn stated that the asbestos siding, to which Claimant was exposed when

drilled or cut or torn apart, resulted in significant exposure to asbestos. In his opinion, the Claimant did not have any asbestos-related lung disease. He did have chronic bronchitis due to tobacco smoking. According to Dr. Renn, the smoking history given him by Claimant was not consistent with the medical records, which showed a considerably greater history of smoking. Dr. Renn found inspiratory crackles which were indicative of a type of interstitial lung disease. Claimant also had an abnormal chest radiograph which was consistent with pneumoconiosis, but it was also consistent with interstitial lung disease, "which can appear exactly the same."

Dr. Renn stated that while there were some reports that irregular opacities can be consistent with pneumoconiosis arising from coal dust exposure, he had never seen this profusion of irregular opacities in coal workers' pneumoconiosis. In his experience, an appearance such as that found in Claimant's radiographs was consistent with idiopathic pulmonary fibrosis. From his pulmonary function testing, the Claimant had changes which looked to be consistent with a mild restrictive ventilatory defect. However, his lung volumes were normal, which eliminated a restrictive ventilatory defect. While from his ventilatory study testing, it appeared the Claimant could perform heavy manual labor, the diffusing capacity study indicated he had a severe reduction of his diffusing capacity, indicative of some destruction of lung tissue and an impairment of gas exchange. This indicated the Claimant could not do heavy manual labor. He could, however, perform moderate labor because he would be able to maintain gas transfer. Dr. Renn explained that he found the UIP to be due to tobacco smoking because it has been found that tobacco smoking is the cause of usual interstitial pneumonitis and the most common type of idiopathic pulmonary fibrosis is usual interstitial pneumonitis. Dr. Renn explained that he did not find asbestosis because the Claimant did not have any other hallmarks of asbestos disease, including pleural plaques on the diaphragms or on the walls and he did not have any calcification of plaques. He also did not have a very marked restrictive ventilatory defect, as would be found if Claimant had that degree of profusion category of asbestosis.

Dr. Renn concluded that Claimant also did not have a presentation of disease typical for someone with coal workers' pneumoconiosis. Claimant's exertional dyspnea began after he was no longer exposed to coal mine dust. Even if the Claimant's shortness of breath and cough had started while he was still exposed to coal mine dust in the 1980s, Dr. Renn stated that his opinion as to the cause of the lung disease would not change because it would have started too late, Claimant had the physiologic and radiographic pictures, and the fact that the Claimant's age and history of smoking make for a diagnosis of usual interstitial pneumonitis. Claimant's presentation on the objective testing was typical for idiopathic pulmonary fibrosis and not for coal workers' pneumoconiosis. Dr. Renn stated he was able to rule out coal mine dust as contributing to Claimant's pulmonary disease because his was a disease of the general population and it was not restricted to any particular group. While he classified Claimant's idiopathic pulmonary fibrosis as being UIP, he could not state with certainty without a biopsy. When asked if Dr. Fino had obtained the same diffusing capacity results as he, Dr. Renn opined that he did and did not know why Dr. Fino found that the Claimant would have difficulty climbing flights of steps and climbing ladders more than once or twice during a shift. When asked, however, if the Claimant would have difficulty climbing multiple flights of steps, Dr. Renn stated that he would have problems with his oxygen transfer process. If allowed to rest to recover between flights, however, he would be able to do his last job. According to Dr. Renn, Claimant would have to stop after two flights of stairs. He opined that Claimant would be unable

to climb three to four flights of steps at one time. According to Dr. Renn, asbestos-related lung disease causes irregular opacities on chest x-ray.

Under § 718.202(a)(4), a claimant may establish the existence of pneumoconiosis, notwithstanding negative x-rays, by submitting reason medical opinions. However, this regulation further provides that any such finding by a physician must be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories. Thus, the Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields, supra.*

Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984). The Board has held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 BLR 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-113(1989), and *Taylor v. Brown Badgett, Inc.*, 8 BLR 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone "does not tend to establish that he does not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 BLR at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Id.*

In this case, the Board found a failure to address whether Dr. Garson's opinion was sufficiently reasoned or whether it was merely a restatement of an x-ray opinion, as well as a failure to address why Dr. Garson's opinion was found to be more persuasive than the contrary opinions of Drs. Fino and Renn. In the same vein, the Board found a failure to address whether Dr. Garson's diagnosis of chronic bronchitis partly attributable to coal dust exposure was sufficiently reasoned.

I find the opinion of Dr. Garson, on the issues of legal and clinical pneumoconiosis to be sufficiently reasoned. Prior to rendering an opinion, Dr. Garson took occupational, medical, and social histories. He completed pulmonary function testing, reviewed medical records, and reports, including the report of Dr. Fino. His deposition testimony, as well as the body of his written report, fully reveals the factors which he considered and the fact that his diagnosis was based on more than just an x-ray reading. Thus, Dr. Garson took into account and discussed objective medical testing, his physical examination of the Claimant, and information about the Claimant's symptoms and work and medical histories, as well as a review of prior medical records. Upon examining the reasoning employed in his medical opinion in light of the objective material supporting his opinion, also taking into account the contrary test results or diagnoses, I find the opinion of Dr. Garson to be well-reasoned and well-documented. In so doing, I also take into account his qualifications and expertise in this area. While Dr. Garson testified that while there was a possibility that there was a mixed dust disease by x-ray, it was simple pneumoconiosis. I do not equate this to a diagnosis which was merely a restatement of an x-ray opinion. Dr. Garson's testimony makes it clear that he relied upon many factors in reaching his conclusions and did not rely solely upon the Claimant's x-ray.

Thus, Dr. Garson also discussed his diagnosis of chronic bronchitis, which he found to have been contributed to by tobacco abuse and coal mine dust. It is apparent that, in rendering his opinion, Dr. Garson took into account the legal definition of pneumoconiosis as well as Claimant's medical conditions, objective laboratory results, and his histories, including that of a significant smoking history.[2] Dr. Garson reviewed medical records and personally examined the Claimant. While he is not board-certified in pulmonary medicine, he is board certified in preventative medicine. His curriculum vitae clearly establishes an expertise in this area and indeed, at one point, he was employed by the instant employer as its medical director.

While Drs. Fino and Renn are pulmonary specialists who based their conclusions on their respective examinations of the Claimant, the objective laboratory testing they performed, and a review of medical records, I do not find their reports to be as persuasive as that of Dr. Garson. In this respect, Dr. Fino does not appear to be aware of Claimant's exposure to asbestos while working in coal mines. He also records only five years of underground coal mine employment, while Claimant indicated fifteen years of such employment. Dr. Fino finds no pulmonary condition due to coal mine work or tobacco abuse, finding a pulmonary fibrosis and a worsening in pulmonary function testing which he attributes to idiopathic pulmonary fibrosis. Dr. Renn diagnoses chronic bronchitis, finding that Claimant does not have any asbestos-related lung disease or coal mine dust related lung disease. He diagnoses a UIP due to tobacco smoking. While Dr. Renn concedes that there were some reports that irregular opacities can be consistent with pneumoconiosis arising from coal dust exposure, he states he has never seen this profusion of irregular opacities in coal workers' pneumoconiosis. Similarly, Dr. Fino also points out that he ruled out pneumoconiosis because there were primarily irregular opacities and there was no

[2] At the hearing, Claimant testified to having smoked two to three packs of cigarettes, having started at the age of seventeen or eighteen years, and having quit smoking cigarettes about fourteen years ago. (Tr. 34-35). He now smokes small cigars once or twice a day, which he does not inhale. (Tr. 34, 45). I find Claimant's testimony regarding his smoking history to be credible.

involvement in the upper lung zones. Their opinions appear to limit their analysis to clinical as opposed to legal pneumoconiosis. It is also significant that Claimant's exposure to asbestos occurred during his coal mine employment. The Board has held that lung disease related to asbestos exposure in coal mine employment may be found to be pneumoconiosis under the Act. *Shaffer v. Consolidation Coal Co.,*17 BLR 1-56, 1-59 (1992). Neither of these physicians appear to consider this point, Dr. Fino in particular, since he finds asbestos exposure would explain his findings, while ruling that out because he had no history from the Claimant of asbestos exposure.

While Drs. Fino and Renn specifically rule out any connection between Claimant's coal mine employment and his pulmonary condition, I find Dr. Garson's opinion to be the more credible on this issue. Dr. Garson fully takes into account the Claimant's exposure to asbestos, tobacco smoke, and coal mine dust, rendering a conclusion which is consistent with the histories given by Claimant, the objective laboratory testing, and the results of his own observations on physical examination of the Claimant and his review of the records herein. I do not find that the opinions of Drs. Fino and Renn to be as thorough or as persuasive. I do not find their reasoning as to why coal mine employment is not a factor in the Claimant's pulmonary condition to be as credible. I find the opinion of Dr. Garson to be worthy of the greater weight.

Accordingly, I find the medical opinion of Dr. Garson is sufficient to outweigh the contrary opinions of Drs. Fino and Renn. Based upon his opinion, I find that Claimant has established the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4). Therefore, I find that the existence of pneumoconiosis has been established pursuant to 20 C.F.R. § 718.202(a)(1) and (a)(4). I further find that the contrary evidence of record is insufficient to outweigh that finding. As Claimant has established the existence of pneumoconiosis, I find that he has established a material change in conditions, warranting a review of the entire record. In this respect, I hereby incorporate the discussion of the prior medical evidence as set forth in my prior decision. I do not find that that evidence is sufficient to outweigh the recent medical evidence which establishes the existence of pneumoconiosis.

Pneumoconiosis Arising Out of Coal Mine Employment

Claimant has established thirty years of coal mine employment. A miner who is suffering or suffered from pneumoconiosis and was employed for ten years or more in one or more coal mines is entitled to a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). As Claimant has over ten years of coal mine employment, he is entitled to the presumption. I do not find the evidence sufficient to rebut the presumption.

Total Disability[3]

In order to be entitled to benefits under the Act, the Claimant must establish total disability due to pneumoconiosis. Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in

[3] As previously found in my prior decision and affirmed by the Board, total disability has not been established pursuant to 20 C.F.R. § 718.204(b)(2)(i)-(iii).

comparable gainful work in the immediate area of the miner's residence. §§ 718.204(b)(1)(i) and (ii). Claimant last worked as a coal miner as a senior construction engineer, a position he held for over a year. That position required that Claimant oversee the maintenance, repair, and construction of preparation plants. Claimant was required to climb the steps of the preparation plant, usually an eight to nine story structure, thirty to forty times a day. This entailed climbing all eight flights. (Tr. 32). During a shift he might walk two to ten miles. (Tr. 28-33). In Answers to Interrogatories, Claimant indicated that the pace of the job was very difficult, as he had to move quickly all day and probably walked about ten miles a day with lots of steps. Claimant testified he did not believe he could perform his last job because he could not do the climbing, because of his breathing problems, and because of his back. (Tr. 45). Claimant testified at the hearing that he walked at a normal or slow pace. However, he explained that he went slowly because if he went any faster, he would be short of breath. (Tr. 33). Claimant also indicated, as set forth above, that the pace of the job was difficult and he had to move quickly all day. I find Claimant's testimony regarding the pace to be credible, further finding that his testimony regarding the fact that he walked more slowly to avoid being short of breath does not detract from the fact that the position entailed a considerable amount of movement and was properly classified as moderate labor.

Section 718.204(b)(2)(iv) provides that total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work. The medical evidence submitted with the Claimant's prior claim, consisting of evidence dating from the 1970s and 1980s is not particularly helpful in assessing Claimant's current medical condition. In his most recent deposition testimony, Dr. Fino opined that the Claimant probably would not have the pulmonary capacity to walk ten miles at a brisk pace and to constantly climb steps. Dr. Garson concluded that Claimant was disabled due to his pulmonary problems, also indicating that his last coal mine work entailed constant climbing throughout his shift and walking at a brisk pace up to ten miles in an eight hour shift. Dr. Renn found that the Claimant would have difficulty performing heavy labor but that he could perform moderate labor. I find, based upon my finding that Claimant's duties entailed moderate labor and that they were accurately described by Dr. Garson in his report, that Dr. Garson's finding of total disability is sufficient to establish same pursuant to 20 C.F.R. § 718.204(b)(iv). In this respect, I find his report sufficiently reasoned on this issue, as he accurately assesses the Claimant's work duties and his ability to perform them. I further find that the deposition testimony of Dr. Fino, regarding his assessment of Claimant's ability to perform that work, also supports this conclusion. I find the opinion of Dr. Renn on this issue to be outweighed.

Having found the existence of total disability by means of the medical opinion evidence, I must now weigh the contrary probative evidence of record. In so doing, I conclude that the contrary probative evidence of record is insufficient to outweigh same. While the pulmonary function and blood gas testing failed to produce values indicative of total disability, it is apparent that Claimant has a significant pulmonary impairment. Accordingly, I find that the existence of total disability has been established pursuant to 20 C.F.R. § 718.204(b).

Total Disability Due to Pneumoconiosis

As total disability has been established, the next issue to be determined is whether the Claimant's total disability is due to pneumoconiosis. Total disability due to pneumoconiosis requires that pneumoconiosis as defined in 20 C.F.R. § 718.201, be a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Substantially contributing cause is defined as having a "material adverse effect on the miner's respiratory or pulmonary condition" or as "materially worsen[ing] a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment." 20 C.F.R §§ 718.204(c)(1)(i) and (ii). Absent a showing of cor pulmonale or that one of the presumptions of § 718.305 are satisfied, it is not enough that a miner suffer from a disabling pulmonary or respiratory condition to establish that this condition was due to pneumoconiosis. *See* § 718.204(c)(2). Total disability due to pneumoconiosis must be demonstrated by documented and reasoned medical reports. *Id.* In this case, I consider the reports of Drs. Fino, Renn, and Garson, as I have found the opinion of Dr. McMonagle to be less than well-reasoned or documented and the medical reports previously submitted with the prior application do not detail Claimant's current medical condition.

When reviewing these three reports, it is important to consider the holding in *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), where the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the claimant did not have pneumoconiosis. The Court noted that there was no case law directly on point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

43 F.3d at 116.

In *Tapley v. Bethenergy Mines, Inc.,* BRB No. 04-0790 (May 26, 2005) (unpub.), the Board held that it was proper for the administrative law judge to discredit the opinions of two physicians with regard to disability causation where these physicians concluded that the miner did not suffer from either legal or clinical pneumoconiosis contrary to the judge's findings. Based upon my finding that Claimant has established the existence of pneumoconiosis and of total disability, I find it proper to discredit the opinions of Drs. Fino and Renn who conclude otherwise. Based upon the medical opinion of Dr. Garson, whose report I have found to be the

most probative, well-reasoned, and well-documented, I find that the Claimant's total pulmonary disability is due to pneumoconiosis pursuant to 20 C.F.R. § 718.204(c)(1).

Entitlement

I find that Claimant has established a material change in conditions and entitlement to benefits. For the reasons set forth in my prior decision, benefits are payable as of September 1, 2001.

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for the Claimant's counsel to submit an application. *Bankes v. Director*, 8 BLR 2-l (l985). The application must conform to 20 C.F.R. §§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including the Claimant and Solicitor as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

ORDER

The claim for benefits filed by John R. McGreevy is hereby GRANTED.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S.

Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).